



APPLICATION FOR CLINICAL SOCIAL WORKER LICENSE

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS

Post Office Box 13446

Macon, Georgia 31208

Phone (478) 207-2440

www.sos.state.ga.us/plb/counselors

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Social Work in the State of Georgia. Visit the following web site for information:

<http://www.sos.state.ga.us/plb/counselors>

****Important****

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The **non-refundable application fee** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (please see Fee Schedule at the Board's website)

Application Checklist

- ☐ **NOTARIZED APPLICATION:** The five-page application must be mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation at its next scheduled meeting. Approval of licensure is at the Board's discretion.
- ☐ **NATIONAL BOARD SCORES:** If you have not taken the CSW exam thru ASWB, you will receive the exam packet information after Board approval. All applicants are required to pass the Association of Social Workers Board (ASWB) national Clinical Social Work Examination. If you have taken the ASWB CSW exam, please contact the National Board Administrative Offices at 1-800-225-6880 and have them certify your scores to Georgia.
- ☐ **DEGREE TRANSCRIPT:** All applicants for licensure must have earned a Master's degree in Social Work and graduated from an institution accredited by the Council on Social Work Education. An **official** college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school.
- ☐ **GEORGIA DOES NOT OFFER ENDORSEMENT OR RECIPROCITY FOR SOCIAL WORK LICENSE:** If you have taken the Clinical Social Work exam thru ASWB, you would apply for license by exam waiver. If you have not taken the Clinical Social Work exam thru ASWB, you would apply for license by exam.
- ☐ **OTHER STATE LICENSURE CERTIFICATION:** If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board's office.
- ☐ **FORM B-DIRECTED EXPERIENCE FROM:** The director/employer must document the on-going administrative oversight of an employee or superior of a practitioner's work.
- ☐ **FORM C-SUPERVISION VERIFICATION FORM:** The directed experience supervisor must document the direct clinical review for the purpose of training or teaching of a Social Worker's interaction with a client(s). Documentation of having acquired 120 hours of supervision during the same period of directed experience.
- ☐ **REFERENCES:** Must have two (2) references by teachers or supervisors who are familiar with their experience in Social Work.
- ☐ **CONSENT FORM:** Please sign the consent form giving permission for the Board to receive any criminal history record information.
- ☐ If your name has changed since you attended school, please make a note on the application advising of your former name(s) so we can match-up the documents with your application.
- ☐ Please access the Board Rules which includes licensure requirements from our website at www.sos.state.ga.us/plb/counselors.
- ☐ **IMPORTANT:** Applicants, please note when accessing your application status on our website under the *Online Services* category *Check the Status of an Application* that checklist items that have been moved over to the completed column only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.

Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists has the authority to approve or deny an application for licensure. Every application file must be submitted to the Board for review. The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board's decision within five to seven working days after the Board meeting.

FOR BOARD USE ONLY

Amount Submitted _____

Date _____

Receipt # _____



FOR BOARD USE ONLY

Certificate Number _____

Date Issued _____

Applicant No. _____

**GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND
MARRIAGE & FAMILY THERAPISTS**

Post Office Box 13446 • Macon, Georgia 31208 • (478) 207-2440

www.sos.state.ga.us/plb/counselors

APPLICATION FOR LICENSE AS A

CLINICAL SOCIAL WORKER

Application Fee \$100 (non-refundable)

Additional License Types (currently or previously issued by the Georgia Professional Licensing Boards): _____

Method Obtained by:

Applicant is applying for above referenced license by:

- ☐ Examination
- ☐ Examination Waiver (only if you have already taken the CSW exam thru ASWB)

Name _____

First Middle Last

Legibly print your legal name (in order to be eligible to take the ASWB exam the name used on the license application must exactly match the name on the valid government issued I.D. used for identification of the ASWB exam.) Failure to comply with this will result in ASWB refusing test entrance to applicant.

Name as shown on exam records or transcripts (if different)

First	Middle	Last
-		-

***Social Security Number** **Date of Birth**

*This information is authorized to be obtained & disclosed to State& Federal agencies pursuant to O.C.G.A.§19-11-1 & O.C.G.A.§20-3-295, 42 U.S.C.A. §551 & 20 U.S.C.A.§ 101.

I am a U.S. citizen.

_____ I am not a U.S. citizen, but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

Physical Address				
Number and Street	Apt. No	City/State	Zip	
<i>P.O. Box not acceptable</i>				

Mailing Address				
(if different)	Number and Street	Apt. No	City/State	Zip

Telephone Number Day	Telephone Number Evening
----------------------	--------------------------

Email Address

PART II - PROFESSIONAL BACKGROUND – ALL APPLICANTS

PROFESSIONAL BACKGROUND: ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.

- ☐ Yes ☐ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?
- ☐ Yes ☐ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
- ☐ Yes ☐ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?
- ☐ Yes ☐ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- ☐ Yes ☐ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- ☐ Yes ☐ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- ☐ Yes ☐ No 7. Have you ever been convicted of any criminal offense?
- ☐ Yes ☐ No 8. Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the "Georgia First Offenders Act? You must respond, "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.
- ☐ Yes ☐ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- ☐ Yes ☐ No 10. Do you now hold or have you ever held a license as a social worker in any jurisdiction? If "yes" complete the following:
Jurisdiction _____ License No. _____
Date Issued _____ Expiration _____
Please request each licensing board submit verification of license to Georgia
- ☐ Yes ☐ No 11. Have you previously applied for the same license for which you are currently applying? If "yes" name under which application was submitted: _____
- ☐ Yes ☐ No 12. Did you receive a Master's Degree in Social Work (MSW) from a Council on Social Work Education (CSWE) accredited school? Date Degree Received _____
Name of School _____
- ☐ Yes ☐ No 13. Did you complete a practicum or internship as part of your MSW Degree Program?
- ☐ Yes ☐ No 14. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

PART III - EXAMINATION WAIVER – ONLY APPLICANTS FOR WAIVER

EXAM TAKEN: I have taken and passed the ☐ Clinical **OR** ☐ Advanced Social Work Examination on _____.

COPY OF SCORE: ☐ I have requested that ASWB submit my score directly to the Board Office.

PART IV - SOCIAL WORK EXPERIENCE – EXAMINATION & EXAMINATION WAIVER APPLICANTS

INSTRUCTIONS:

- In answering Questions 3 - 7 below:

- **Prior to 6/30/96** — One (1) year of Direct Experience = 800 hours in not less than 12 months or more than 36 months.
- **After 7/1/96 - One** (1) year of Direct Experience = 1,000 hours in not less than 12 months or more than 36 months.

- Supervision must have been by a qualified supervisor, as required by Board Rule Chapter 135-5-.03(3)(d) and verified on Form C - Supervisor Verification.]

- | | | |
|--|----|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. | Do you have an earned Master's Degree in Social Work (MSW) from a program in a school accredited by the Council on Social Work Education (CSWE) in which candidacy, conditional or accreditation status was in effect when the degree was awarded? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. | Did you complete a practicum or internship as part of your MSW Degree Program? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. | Do you have three (3) years of full-time experience in the practice of Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. | Do you have two (2) years of full time experience in the practice of Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. | Do you have a Doctoral Degree in: <input type="checkbox"/> Professional Counseling, <input type="checkbox"/> Social Work, <input type="checkbox"/> Marriage and Family Therapy, <input type="checkbox"/> Medicine, <input type="checkbox"/> Psychiatric Nursing, <input type="checkbox"/> Applied Psychology, <input type="checkbox"/> Pastoral Counseling or <input type="checkbox"/> Applied Child and Family Development which you want the Board to consider in lieu of the required years of supervised Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. | Do you have: <input type="checkbox"/> Thirty two (32) hours of supervision per year for years prior to 7/1/96 OR <input type="checkbox"/> Forty (40) hours of supervision after 7/1/96, as defined above as documented on Form C - Social Work Supervision Verification Form? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. | Have you obtained at least one (1) year of full time experience in the 36-month period prior to your Application? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. | Have you obtained eighteen (18) hours of Continuing Education during the last twelve (12) months that conforms to Board Rule Chapter 135-9-.01? |

PART V - DIRECTED EXPERIENCE – EXAMINATION & EXAMINATION WAIVER APPLICATIONS

INSTRUCTIONS:

- See below and check the appropriate section [1 - 4] for your Directed Experience and how you intend to show that you meet the requirements.
- List the name(s) of the Director(s) under whom you fulfilled the experience requirement for licensure and include the date(s) of employment.
- Have each Director complete a separate Form B — Professional Experience Verification Form to demonstrate that you meet the minimum experience requirement for licensure.
- See Board Rule Chapter 135-5-.04(5).

I obtained Directed Experience:

1. ☐ **Between July 1, 1987 and July 1, 1996** and am presenting evidence of:
 - ☐ At least 800 hours of supervised experience within the two (2) years immediately preceding this Application **OR**
 - ☐ Having met the continuing education requirement during the year immediately preceding this Application [at least 2.5 hours ethics, 10 core hours and 5 related hours].**AND Prior to July 1, 1996**, I am presenting evidence:
 - ☐ Of having practiced Clinical Social Work for a minimum of 2400 hours of supervised Post-Master's Degree Social Work Experience over a period of no less than 36 months and no more than 108 months, the first 1600 hours of which were under supervision and direction in Clinical Social Work practice **AND**
 - ☐ That I also have 96 hours of supervision, 64 of which may be group supervision and 64 of which must have been provided by a licensed Clinical Social Worker.
2. ☐ **After July 1, 1996** — I am presenting evidence of:
 - ☐ At least 1000 hours of supervised experience within two (2) years immediately preceding this Application **OR**
 - ☐ Having met the continuing education requirement during the year immediately preceding this Application [at least 2.5 hours ethics, 10 core hours and 5 related hours]. **AND**☐ Of having practiced Clinical Social Work for a minimum of 3000 hours post Social Work Master's Degree supervised experience acquired over a period of no less than 36 months or more than 108 months, the first 2000 hours of which were under supervision and direction in the practice of Clinical Social Work **AND**
 - ☐ Documentation of having acquired 120 hours of supervision during this time, no more than 50% of which was group supervision and at least 50% of which was provided by a licensed clinical social worker duly qualified as a supervisor. **OR**
 - ☐ I have shown hardship or good cause and ask the Board to extend the time to acquire supervision and/or experience.
3. ☐ **I hold a Master's Degree in Social Work AND a Doctoral Degree in:** Professional Counseling, Social Work, Marriage and Family Therapy, Medicine, Psychiatric Nursing, Applied Psychology, Pastoral Counseling or Applied Child and Family Development which degree program included a Supervised Clinical Internship and **wish to substitute this for one (1) year of supervision. AND**
 - ☐ I have **experience prior to July 1, 1996** and:
 - ☐ I have presented evidence of two (2) years (1600) hours of Post-Master's Supervised Experience under direction in the practice of Clinical Social Work, obtained in no less than 24 months nor more than 72 months. **AND**
 - ☐ I have documented 64 hours of supervision (in addition to the clinical internship), 50% of which was supervised by a Social Worker, a maximum of 50% of which was group supervision.

- ☐ I have **experience after July 1, 1996** and:
- ☐ I have presented evidence of two (2) years full time supervised Post-Master's Degree Experience (2000 hours) under direction in the practice of Clinical Social Work obtained in no less than 24 months and no more than 72 months. **AND**
 - ☐ I have documented 80 hours of supervision by a duly qualified supervisor, 50% of which may be group supervision; 50% of which was provided by a licensed Clinical Social Worker. **OR**
 - ☐ I have shown hardship or good cause and ask the Board to extend the time to acquire supervision and/or experience.

NAME OF DIRECTOR:

DATES OF EMPLOYMENT:

FROM:

TO:

NAME OF DIRECTOR:

DATES OF EMPLOYMENT:

FROM:

TO:

NAME OF DIRECTOR:

DATES OF EMPLOYMENT:

FROM:

TO:

PART VI –SUPERVISION – EXAMINATION & EXAMINATION WAIVER APPLICANTS

INSTRUCTIONS:

- List the name(s) of the Supervisor(s) under whom you fulfilled the experience requirement for licensure and include the date(s) of employment and check applicable period below.
- Have each Supervisor complete a separate Form C — Professional Experience Supervision Verification Form to demonstrate that you meet the minimum experience requirement for licensure.
- See Board Rule Chapter 135-5-.04(5)
- Supervision **prior to July 1, 1987** - Supervisor must either be a licensed Psychologist or Psychiatrist OR have an earned Master's Degree in Social Work from a CSWE-accredited program **AND** one (1) year of supervision means 32 hours of clinical supervision in no less than 12 months and no more than 36 months.
- Supervision **between July 1, 1987 and July 1, 1996** - Supervisor must be licensed as a Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist or a member of the Academy of Certified Social Workers.
- Supervision **after July 1, 1996** - Supervisor must be a licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist and have practiced in their specialty for at least 200 clock hours over a minimum of two (2) years after licensure AND one year means 40 hours of clinical supervision in no less than 12 months and no more than 36 months.

NAME OF SUPERVISOR:

DATES OF SUPERVISION

FROM:

TO:

NAME OF SUPERVISOR:

DATES OF SUPERVISION

FROM:

TO:

NAME OF SUPERVISOR:

DATES OF SUPERVISION

FROM:

TO:

PART VII – EDUCATION – EXAMINATION & EXAMINATION WAIVER APPLICANTS

NAME OF COLLEGE/UNIVERSITY WHERE YOU OBTAINED YOUR MASTER'S IN SOCIAL WORK:

PART VIII – OATH – ALL APPLICANTS

I attest that to the best of my knowledge and belief the information provided above is true and accurate. I acknowledge that I may be required to furnish additional information promptly for this Application to be processed.

Date

Signature of Applicant

Sworn to and subscribed before me this

_____ day of _____, _____

Notary Public

My Commission Expires _____

NOTARY SEAL



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SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) * (866) 888-7130 (Fax)
www.sos.state.ga.us/plb/counselors

APPLICATION FOR CLINICAL SOCIAL WORKER LICENSE BY EXAMINATION
SOCIAL WORK DIRECTED EXPERIENCE VERIFICATION FORM
FORM B

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please print or type.
- **APPLICANT** – Complete Part I and forward this form to the agency or organization in which you completed your directed experience practicing Social Work.
- **AGENCY OR ORGANIZATION** - The Director must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.

PART I – APPLICANT

NAME OF APPLICANT:

First Middle Last Maiden

SOCIAL SECURITY NUMBER: _____

This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

PART II – AGENCY OR ORGANIZATION

INSTRUCTIONS:

- "Direction" means the on-going administrative oversight of an employer or superior of a practitioner's work.
- For experience obtained **before 6/30/96**, one year of Directed Experience means a minimum of 800 hours in the practice of Social Work during a 12-month period within two (2) years of the application.
- For experience **after 7/1/96**, one year of Directed Experience means a minimum of 1000 hours in the practice of Social Work for no less than a year during 36 months preceding the application.

CERTIFICATION

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL PRACTICED SOCIAL WORK AT:

Name of Agency or Organization _____

Address: _____

Street City State Zip Code

From : _____ To: _____ For _____ City State Zip Code

(MUST DOCUMENT DATE DO NOT USE "PRESENT")

Date _____ Signature of Director or Authorized Person _____

Name of Agency or Organization _____ Printed Name _____

_____ Title/Position _____

_____ Street Address _____

_____ City State Zip Code

Telephone: () _____ Fax: () _____



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APPLICATION FOR CLINICAL SOCIAL WORK LICENSE BY EXAMINATION
SOCIAL WORK SUPERVISION VERIFICATION FORM
FORM C

INSTRUCTIONS: Please print or type. **NO FAXED FORMS ACCEPTED.**

APPLICANT

- **Complete Part I** and forward this form to each supervisor from the organization or agency in which you completed your directed experience practicing Social Work. Complete a separate form for each Directed Experience Supervisor listed in your application. Use this form to only verify Social Worker supervision.
- If you need additional forms, you may photocopy this form.

DIRECTED EXPERIENCE SUPERVISOR

- The Directed Experience Supervisor must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.
- "Supervision" means the direct clinical review by a Supervisor for the purpose of training or teaching of a Social Worker's interaction with a client.

PART I - APPLICANT

NAME OF APPLICANT: _____
First Middle Last Maiden

SOCIAL SECURITY NUMBER: _____

PART II - DIRECTED EXPERIENCE SUPERVISOR

I HEREBY CERTIFY THAT I SUPERVISED THE ABOVE-NAMED INDIVIDUAL IN THE PRACTICE OF SOCIAL WORK AS FOLLOWS:

INDIVIDUAL SUPERVISION:

Total Hours:	Hours Per Week:	From:	To:
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GROUP SUPERVISION:

Total Hours:	Hours Per Week:	From:	To:
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DESCRIPTION OF PRACTICE SUPERVISED:

I attest that I served as this Applicant's Directed Experience Supervisor, as defined above, that this description is a true and accurate representation of my supervision of this Applicant, and I:

☐ Recommend ☐ Do Not Recommend this Applicant for licensure.

Date Signature of Directed Experience Supervisor

Years of Experience After License Issued:	Printed Name:
---	---------------

Address: _____
Street City State Zip Code

Telephone #: ()	Fax #: ()
------------------	------------

License Type:	License #:	State:	Date Issued:	Exp. Date:
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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE
PERSONAL REFERENCE FORM
FORM D

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED.**

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Social Work.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.
The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name: _____

PART II - REFERENCE

Name: _____

Address: _____

Day Phone: () _____

Other Phone: () _____

Relationship to Applicant: _____

☐ Teacher

☐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: _____ TO: _____
Month/Day/Year Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:

Title: _____

Agency/Institution: _____

Address: _____

RECOMMENDATION: I ☐ Recommend ☐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date _____

Signature of Reference _____



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CLINICAL SOCIAL WORKER
DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM E

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.

The Directed Experience Supervisor must be:

PRIOR TO JULY 1, 1987 — A licensed Psychologist, Psychiatrist or have earned an MSW from a CSWE-accredited program.

JULY 1, 1987 - JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist or a member of the Academy of Certified Social Workers.

AFTER JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist or Psychiatrist and has practiced in their specialty for at least 2000 clock hours over 2 years following licensure. See Board Rule Chapter 135-5-.04(5)(f) -(h).

APPLICANT:

- Make every effort to locate the as many of the supervisors of Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

I obtained experience: ☐ Prior to July 1, 1987 ☐ July 1, 1987 - July 1, 1996 ☐ After July 1, 1996

PART II - OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____

who served as my supervisor while I worked under the direction of: _____

at: _____ Name of Director

_____ Name of Agency or Organization Address City State Zip

and that this supervisor has the following credentials:

License Type: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapist ☐ Psychologist
☐ Psychiatrist ☐ Member of the Academy of Certified Social Workers
☐ Earned an MSW from a CSWE-accredited program

License #: _____ State: _____ Date Issued: _____ Expir. Date: _____ Years of Practice After Licensed: _____

The supervision of my Social Work Practice was provided during the following 12-month period/s:

YEAR 1 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 2 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 3 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 4 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:

Date
Sworn to and subscribed before me this
_____ day of _____, _____.

Signature of Applicant

Notary Public
My Commission Expires: _____

NOTARY SEAL



OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I authorize the **Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists** to conduct a background investigation of me to determine my suitability for licensure. I give my consent for full and complete disclosure of all records and information concerning myself to the Board, their authorized representatives, or any other persons deemed necessary by the Board in determining my suitability, whether such records and information are of a public, private, or confidential nature, to include criminal history records. This authorization will remain in effect for the duration of my active licensure status with this state or until cancelled by me in writing.

Applicant's Full Name (Printed)

Physical Address (P.O. Boxes **NOT** Accepted)

Sex

Race

Date of Birth

Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

(Signature of Applicant)

(Date)